

Medical Prior Authorization Form

Fax completed form to: 877.974.4411 toll free, or 616.942.8206

This form applies to: Commercial (Traditional) Commercial (Individual/Optimized)

Medicaid

This request is: Urgent (life threatening) Non-Urgent (standard review)

Urgent means the standard review time may seriously jeopardize the life or health of the patient or the patient's ability to regain maximum function.

Supprelin LA[®] (histrelin acetate implant)

Member

Last Name: _____ First Name: _____
 ID #: _____ DOB: _____ Gender: _____
 Primary Care Physician: _____
 Requesting Physician: _____ Phys. Phone: _____ Phys. Fax: _____
 Physician Address: _____
 Physician NPI: _____ Contact Name: _____
 Provider Signature: _____ Date: _____

Product and Billing Information

New request Continuation request

Drug product: Supprelin LA 50 mg implant **Start date (or date of next dose):** _____
Date of last dose (if applicable): _____
Dosing frequency: _____

Place of administration: Physician's office
 Outpatient infusion
 Facility: _____ NPI: _____ Fax: _____
 Home infusion
 Facility: _____ NPI: _____ Fax: _____

Billing: Physician to buy and bill
 Facility to buy and bill
 Specialty Pharmacy
 Pharmacy: _____ NPI: _____ Fax: _____

ICD-10 Diagnosis code(s): _____

Precertification Requirements

Before this drug is covered, the patient must meet all of the following requirements (duration of approval is 12 months):

1. Documentation of a diagnosis of Central Precocious Puberty in a patient aged 2 years or older.
2. Documented inadequate response to or intolerance to an adequate trial of Lupron injections.

Note: Authorization for indications, dosing, or a route of administration not approved by the Food and Drug Administration (FDA) or recognized in CMS-accepted compendia (e.g. DrugDex, AHFS, U.S. Pharmacopeia, and also Clinical Pharmacology for oncology indications only) require supporting evidence for coverage. Please provide two published peer-reviewed literature articles supporting the appropriateness of the drug, the dosing of the drug, or the route of administration to be used for the identified indication.

Priority Health Precertification Documentation

A. What condition is this drug being requested for?

Central Precocious Puberty

Other, rationale for use: _____

B. Has the patient had an inadequate response to or intolerance to an adequate trial of Lupron injections?

Yes No, rationale for use: _____